General
Dental
Council

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award
University of Manchester	BSc Oral Health Science

Outcome of Inspection	Recommended that the BSc Oral Health Science continues to be approved for the graduating cohort to register as a dental hygienist and a dental therapist but that the approval of future cohorts is contingent on a reinspection in 2024/25.

Full details of the inspection process can be found in Annex 1

Inspection summary

Remit and purpose of inspection:	Inspection referencing the *Standards for Education* to determine sufficiency (BDS) and approval (BSc) of the award for the purpose of registration with the GDC as a dentist (BDS) and a dental hygienist and dental therapist (BSc). Risk based inspection focused on Requirements 2, 4, 5, 9, 10, 11, 12, 13, 14, 15, 19 and 20.
Learning Outcomes:	Preparing for Practice (dental hygiene; dental therapy: BSc)
Programme inspection dates:	14 & 15 February 2024
Sign-off meetings:	10 April 2024 10 July 2024
Inspection team:	Kim Tolley (Chair and non-registrant member) Joanne Brindley (DCP member) Kathryn Fox (Dentist member) Martin McElvanna (GDC Education Quality Assurance Officer) Kathryn Counsell-Hubbard (Quality Assurance Manager, July sign-off meeting only)
Report Produced by:	Martin McElvanna (GDC Education Quality Assurance Officer) Kathryn Counsell-Hubbard (Quality Assurance Manager)

This was a follow-up inspection of both the BDS and BSc Oral Health Science following an Urgent Inspection on 3 April 2023. The risk-based inspection focused on Requirements 2, 4, 5, 9, 10, 11, 12, 13, 14, 15, 19 and 20.

The programme inspection was conducted on site at the Division of Dentistry (‘the Division’) at the University of Manchester.

The inspection panel was comprised of GDC education associates (‘the panel’, ‘we’). The panel were grateful for the documents received in advance of the inspection and some further documents that were made available on site during the inspection.

The panel noted the progress made against the recommendations following the Urgent Inspection in 2023 and the Division are to be commended for this. In particular, several staff vacancies had been filled and internal promotions had taken place.

The panel noted that there is good team and student interaction between the BDS and BSc programmes. However, since the onsite inspection, the panel have become aware of the

overall student dissatisfaction with the University as a whole due to the results from the National Student Survey.

The panel observed two meetings following the onsite inspection where it was identified that some learning and development by the team is required, which will be addressed by this report.

Overall, the panel could see the positive progress made by the programme team and noted that a new central recording system is due to be implemented which may address some of the issues identified. However, some significant concerns regarding the signing-off of students still persists and that this should be reviewed via a reinspection in the next academic year.

The GDC wishes to thank the staff, students, and external stakeholders involved with the BSc programme for their co-operation and assistance with the inspection.

Background and overview of qualification: BSc Oral Health Sciences

Annual intake	15 students
Programme duration	109 weeks over 3 years
Format of programme	Years 1: basic knowledge, EBL, small group seminars, joint lectures with BDS, simulated clinical practice, shadowing 2: small group seminars, joint lectures with BDS, simulated clinical practice, clinics 3: small group seminars, direct patient treatment, outreach
Number of providers delivering the programme	(1) Manchester university Foundation Trust (MFT) (2) Oldham Road Dental Practice (3) Implant Clinical Excellence (ICE)

Outcome of relevant Requirements[1]

Standard One	
2	Met
4	Partly Met
5	Partly Met
Standard Two	
9	Partly Met
10	Partly Met
11	Partly Met
12	Partly Met
Standard Three	
13	Partly Met
14	Partly Met
15	Partly Met
19	Partly Met
20	Partly Met

Standard 1 – Protecting patients
Providers must be aware of their duty to protect the public. Providers must ensure that patient safety is paramount and care of patients is of an appropriate standard. Any risk to the safety of patients and their care by students must be minimised.

Requirement 1: Students must provide patient care only when they have demonstrated adequate knowledge and skills. For clinical procedures, the student should be assessed as competent in the relevant skills at the levels required in the pre-clinical environments prior to treating patients.

Requirement 2: Providers must have systems in place to inform patients that they may be treated by students and the possible implications of this. Patient agreement to treatment by a student must be obtained and recorded prior to treatment commencing. ***(Requirement Met)***

At the inspection, we learnt about the success of the BUPA pilot with the commissioning of two new outreach centres, one of which is used exclusively by the programme's students for two days per week.

[1] All Requirements within the *Standards for Education* are applicable for all programmes unless otherwise stated. Specific requirements will be examined through inspection activity and will be identified via risk analysis processes or due to current thematic reviews.

Ahead of the inspection, we had been provided with evidence of the patient consent form used at Manchester Dental Hospital on the Consultant and triage clinics, which the patient physically signs. We have also been given details of the electronic consent forms used for patient treatment.

We heard about the implementation of a new patient electronic record system (HIVE) which contains electronic patient consent forms that were previously paper based.

If a patient declined to be treated by a student at any placement, they would be directed to general practice instead.

Students wear badges and identifiable uniforms at the Manchester Dental Hospital.

We considered this Requirement was Met.

Requirement 3: Students must only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care, including equality and diversity, wherever treatment takes place.

Requirement 4: When providing patient care and services, providers must ensure that students are supervised appropriately according to the activity and the student's stage of development. ***(Requirement Partly Met)***

The panel received a staff-student supervision policy dated 7 February 2024. However, we noted it didn't contain reference to supervision for paediatric patients and outreach clinics.

During the inspection we were assured that in the absence of allocated supervisors or a risk of low staff: student ratio, other tutors would be sourced and failing that, a clinic would be cancelled. The ongoing recruitment of new tutors should help as they will be able to work between zones at the Dental Hospital, allowing for a greater spread of supervision.

The panel considered that the Division must continue to work on the development and implementation of the new staff to student supervision policy, covering all areas of clinical work and the various outreach centres.

This Requirement is considered to be Partly Met.

Requirement 5: Supervisors must be appropriately qualified and trained. This should include training in equality and diversity legislation relevant for the role. Clinical supervisors must have appropriate general or specialist registration with a UK regulatory body. ***(Requirement Partly Met)***

At the inspection we heard that all Trust staff must undergo annual Mandatory Training which includes equality, diversity and inclusion. This is reviewed during the annual performance and development review process.

All supervisors must have registration with the GDC, and this is checked during the appointment process. Evidence of registration must be provided at the beginning of each year.

By way of induction, all new University staff must complete several mandatory training courses including health and safety, data protection, cyber security, diversity in the workplace, unconscious bias and disability equity.

The panel noted that monitoring of staff training appeared to be reliant on the centres and on assurance from the NHS and CQC reports for staff compliance, and that the Division didn't appear to have a central staff monitoring system.

The panel consider that the Division must consider a central tracking and monitoring system to monitor staff training including EDI training and GDC registration.

This Requirement is considered to be Partly Met.

Requirement 6: Providers must ensure that students and all those involved in the delivery of education and training are aware of their obligation to raise concerns if they identify any risks to patient safety and the need for candour when things go wrong. Providers should publish policies so that it is clear to all parties how concerns should be raised and how these concerns will be acted upon. Providers must support those who do raise concerns and provide assurance that staff and students will not be penalised for doing so.

Requirement 7: Systems must be in place to identify and record issues that may affect patient safety. Should a patient safety issue arise, appropriate action must be taken by the provider and where necessary the relevant regulatory body should be notified.

Requirement 8: Providers must have a student fitness to practise policy and apply as required. The content and significance of the student fitness to practise procedures must be conveyed to students and aligned to GDC Student Fitness to Practise Guidance. Staff involved in the delivery of the programme should be familiar with the GDC Student Fitness to Practise Guidance. Providers must also ensure that the GDC's Standard for the Dental Team are embedded within student training.

Standard 2 – Quality evaluation and review of the programme
The provider must have in place effective policy and procedures for the monitoring and review of the programme.

Requirement 9: The provider must have a framework in place that details how it manages the quality of the programme which includes making appropriate changes to ensure the curriculum continues to map across to the latest GDC outcomes and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this function. (Requirement Partly Met)

The Division has an Assessment and Examination Group (AEG) which is chaired by the Programme's Assessment Lead, a newly formed Curriculum Development Committee (CDC) and a Staff Student Liaison Committee (SSLC).

The provider explained that the UG Programme Committee (UPC) and Dental Leadership Team (DLT) meet monthly to discuss issues or proposed changes relating to the curriculum.

Prior to the inspection, the panel had sight of minutes from the SSLC, AEG and SSLC.

At the inspection, we met the Curriculum Review and Development Lead who explained the mapping work that had been recently undertaken to ensure coverage and assessment of the current GDC learning outcomes. We noted there is a second phase of this work which will be completed over the next few months. It was also noted that the GDC has published a new Safe Practitioner framework, and that work will be required to transfer mapping to this document.

The Division must provide an update to the ongoing curriculum mapping work to the GDC learning outcomes and preparation to move to the new Safe Practitioner Framework.

This Requirement is considered to be Partly Met.

Requirement 10: Any concerns identified through the Quality Management framework, including internal and external reports relating to quality, must be addressed as soon as possible and the GDC notified of serious threats to students achieving the learning outcomes. The provider will have systems in place to quality assure placements. ***(Requirement Partly Met)***

The Division explained that any reports and concerns which relate to the programme are dealt with as a matter of urgency via the UPC, AEG, or DLT. The Division also has strong lines of communication with the School of Medical Sciences Board, the Faculty of Biology, Medicine and Health's Teaching and Learning Committees and the University's Teaching and Learning Strategy Group.

The Division explained that it has a Risk Register which is reviewed at the UPC. This is supported by an internal quality assessment process that was piloted in 2023 and is being rolled out in 2024. The panel noted that the Risk Register appeared to have only two items on it: patient complaints and low staff morale. We learnt that there is a separate Trust Risk Register which includes risks to clinical governance and patient safety. A more comprehensive in-house risk register would be useful for the Division to keep track of all relevant incidents and to highlight future potential areas of concern.

The panel was aware that student representatives had reported problems with administrative support in the SSLC minutes. These issues are being addressed at the SSLC and have been escalated to Division staff, and some improvements had been noted. Quite a few of the problems were related to the roll-out of the new HIVE system and patient allocation.

The panel was aware that there had been ongoing issues regarding student timetables. We learnt that this has been caused due to a transfer between administrative teams and that there were some difficulties with the handover which led to timetabling clashes. Some staff were new to dentistry and have had to learn the basics for clinic scheduling requirements and the variability between clinics. New staff have also been recruited. As a result, the timetabling has much improved.

The panel learnt about the high numbers of patient complaints in 2023. This related to student treatment, excessive patient expectations of treatment and a significant number of lost appointments. We were assured that this was largely because of a challenging transfer to the HIVE system and issues with patient lists. These issues have now been rectified with extensive student training and there had been no patient complaints in the month of January 2024. The Division has indicated that a service evaluation is being conducted and we would like to see this in due course.

The Division explained that the Programme Team completes an annual Student Experience Action Plan (SEAP) following continuous monitoring, reflection on the previous academic year and planning for the forthcoming academic year. It takes into account student feedback. The SEAP is faculty-driven, and the Division indicated that it needs to complete one specifically for dentistry. The panel recommends that this is completed as suggested.

At the inspection, the panel noted the positive staff developments with vacancies being filled and several staff members taking on new and existing leadership positions. This has made programme support more stable and has alleviated the workload on the senior programme

team. The panel recommends that the Division continue to work on staff recruitment, development and succession planning.

This Requirement is considered to be Partly Met.

Requirement 11: Programmes must be subject to rigorous internal and external quality assurance procedures. External quality assurance should include the use of external examiners, who should be familiar with the GDC learning outcomes and their context and QAA guidelines should be followed where applicable. Patient and/or customer feedback must be collected and used to inform programme development. ***(Requirement Partly Met)***

The Division explained that the University uses an annual meeting of the Teaching and Learning Strategy Group (TLSG) to review teaching and learning. This Group oversees development of policies, procedures and structures for teaching and learning.

The Division explained that the programmes have both a programme External Examiner (EE) and a number of subject EEs. They provide an annual report which is considered by the Programme Assessment Lead and a formal response given.

The Division explained that the University is currently reviewing and developing its processes for periodic review. Whilst this is under review and development, the University has adopted a risk-based approach and will undertake a review on request by a programme area. It is expected that that a new process will be approved and implemented for the start of the next academic year (2024/25).

There is further discussion regarding EEs at Requirement 20.

The panel heard examples of when student feedback led to changes in assessments and systems. We also heard about patient feedback. Patient complaints were largely due to administrative issues, but otherwise feedback on students was good.

The panel found the majority of the Requirement to be Met, but upon attending the final student sign-off meeting noted the absence of the EE. This was not addressed by any of the programme team. We heard at the April sign-off that a recording of the meeting would be submitted to the EE for review, but this was not mentioned at the July meeting. The panel could not be assured in this instance that appropriate quality assurance was being completed at such a key decision point, which impacts on their achievement of the Requirement. The Division must ensure that external quality oversight must be utilised at all stages and that the absence of this is justified and minuted.

This Requirement is therefore considered to be Partly Met.

Requirement 12: The provider must have effective systems in place to quality assure placements where students deliver treatment to ensure that patient care and student assessment across all locations meets these Standards. The quality assurance systems should include the regular collection of student and patient feedback relating to placements. ***(Requirement Partly Met)***

The Division confirmed the appointment of a new Lead for Outreach. It has developed a standard proforma for outreach audits. Although the panel had sight of a template outreach evaluation form, we didn’t see a completed one. The Division should provide examples of completed evaluation forms following the expansion of placement provision.

There is also a standard memorandum of understanding for all future placements, which includes roles and responsibilities for both the University and the placement partner. Placement providers are given a contextualised handbook which includes their roles and responsibilities, and the expectations of Manchester and their students.

At the inspection we learnt that the BUPA pilot has proven to be highly successful, with an initial two centres being used. They are currently in the recruitment phase for additional clinical supervisors. BUPA is actively engaging with Manchester. The expansion involves onboarding five practices in phased intervals during 2024, each of which will be equipped with two dental chairs.

The Division meets BUPA regularly and the panel noted they have a good relationship.

The panel had concerns that the new Lead for Outreach is employed on 0.1 full time equivalent basis, particularly given the broad coverage of the role, ongoing developments and prospective expansion to placements. We recommend the Division consider expanding the employment basis for the Outreach Lead.

We noted an apparent lack of formal training to outreach supervisors or induction. In addition, we note that the staff away day agenda didn't have any content regarding calibration and training. The panel recommend that the Division consider the standardisation of induction and training for placement supervisors.

This Requirement is considered to be Partly Met.

Standard 3– Student assessment
Assessment must be reliable and valid. The choice of assessment method must be appropriate to demonstrate achievement of the GDC learning outcomes. Assessors must be fit to perform the assessment task.

Requirement 13: To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, and that they are fit to practise at the level of a safe beginner. Evidence must be provided that demonstrates this assurance, which should be supported by a coherent approach to the principles of assessment referred to in these standards. *(Requirement Partly Met)*

Prior to the inspection we had received the handbook of Milestones and Gateways which outlines the information gathered for clinical progression, including gateways, procedural targets and written and observed milestones.

Students also have a range of clinical milestones to complete which assess their competency in different procedures. Procedures usually completed in one appointment are completed as observed milestones, where their tutor grades the encounter on a range of criteria.

Milestone data is currently recorded on paper, handed into the office, and then uploaded. There are plans to do this electronically.

The panel were grateful to observe the first sign-up meeting on 14 February 2024. We noted the discussion across a range of criteria, such as absences, professionalism rating cards, milestones and gateway data, and direct and indirect clinical procedures. We also observed the range of outcomes being issued. Some outcomes were issued with conditions for students to undertake further specific clinical activities.

At the inspection, we were taken through a helpful demonstration of student monitoring and recording systems.

However, the panel had some concerns about the robustness of clinical data capture. For example, the complexity of procedures was not captured within the data so the panel could not discern if an appropriate number of complex procedures had been completed or a low number of simple procedures. The data therefore did not adequately demonstrate that students were meeting the levels of competency required to pass the programme. It was also evident that the visibility of overall student progress, with respect to longitudinal clinical assessment of students, was not possible.

The panel noted that although single and multi-surface restorations were captured on the master spreadsheet, this was not discussed or viewed when the data was presented at the Sign-up panel. Only overall totals were reviewed. The panel considered that without knowing how many complex procedures have been undertaken and at what grade (bearing in mind that the SP (procedural intervention) grade was deemed to be acceptable as a threshold for passing a milestone), the Sign-up panel does not have full insight into each student's clinical experience. The range of clinical activities undertaken within paediatrics was also not visible.

These concerns were further compounded upon attendance at sign-up meetings in April and July when the total was not examined in any greater depth to ensure the appropriate spread of simple and complex procedures prior to passing the course.

Further to this, the panel noted that non-clinical considerations, such as attendance and professionalism, were not included within the final sign-up meeting. Although an incident of extreme unprofessionalism is recorded by a red card system, there was no evidence of a review of the general levels of professional behaviours or communication skills.

The use of clinical totals without examination of a potential registrant's behaviour and full skillset could pose a risk to the patients the student will treat when they graduate from the programme. The panel were assured through a review of clinical evidence and assessment data that the current graduating cohort met the level of a safe beginner, but were not assured that this would be the case for future cohorts due to not drawing together all types of student data for a more robust assessment. The processes to make decisions are in place, and the panel is hopeful that the introduction of the CAFS system will allow for the additional depth required, but at present the Division's ability to make fully formed decisions as to a student's capability and safety is limited.

The panel also had concerns over the robustness of the use of thresholds during assessments, required for clinical progression. For example, we noted there was no differentiation between the threshold levels that students were expected to achieve, for both basic or more complex procedures. As an example, relating to dentistry milestones, a student can pass a programme based on a series of novice level grades, but according to the rubric this indicates that they would still require additional training. This means that students can graduate by completing all their milestones, both basic and complex, at "Sp" level, and even though deemed "satisfactory", procedural tutor assistance is still required.

Additionally, we considered that there was the potential for students to be strategic in choosing simpler procedures in order to meet their clinical targets.

The Division must introduce explicit presentation of clinical data as described above as an urgent change alongside capturing the students' longitudinal development and the complexity of their clinical experience.

The Division must also address the apparent lack of differentiation in the threshold levels between basic and complex procedures.

This Requirement is considered to be Partly Met.

Requirement 14: The provider must have in place management systems to plan, monitor and centrally record the assessment of students, including the monitoring of clinical and/or technical experience, throughout the programme against each of the learning outcomes. ***(Requirement Partly Met)***

As detailed at Requirement 13, the panel were grateful for a student progression demonstration meeting which illustrated the current systems in place for monitoring student data and progression. A system is in place and is used for making progression decisions, but this needs urgent improvement to ensure that future cohorts are fit to graduate.

The Division must introduce the new student monitoring systems as soon as possible and consider interim measures for capturing additional data should the CAFS system not be available when the next progression decisions are due to be made.

This Requirement is considered to be Partly Met.

Requirement 15: Students must have exposure to an appropriate breadth of patients/procedures and should undertake each activity relating to patient care on sufficient occasions to enable them to develop the skills and the level of competency to achieve the relevant GDC learning outcomes. ***(Requirement Partly Met)***

Prior to the inspection, we had been provided with the Handbook to gateways and milestones and the School Programme Handbook, both of which have been significantly updated.

As discussed earlier, there had been an issue with shortage of patients due to the implementation a new database (HIVE) which has now been resolved.

BDS students attend the Manchester Dental Hospital. BSc students also go to other placements than the BDS including a new practice in Oldham (replacing Bateman and Best in Liverpool), the ICE implant centre and Trafford Hospital.

At the inspection, students indicated that they see a good range of patients, particularly from some deprived areas and are able to acquire broad experience as required but would be grateful for greater patient numbers.

We learnt that some patients have been accessed through a government initiative focused on returning people back to work. This is a commendable initiative.

As discussed earlier, the BUPA pilot has been a success and is being rolled out across additional placements during 2024.

Despite the progress made and initiatives taken in certain areas, the panel could not be assured of an appropriate breadth of clinical experience due to the lack of detail in the clinical experience data, as discussed under Requirement 13. We did not see any additional checks or level of detail at the sign-off meetings attended that demonstrated robustness of experience, and while the current cohort are considered to meet the level of safe beginner, such a determination cannot be made for future cohorts based on the evidence seen to date.

We note that the CAFS system should address a number of concerns.

This Requirement is considered to be Partly Met.

Requirement 16: Providers must demonstrate that assessments are fit for purpose and deliver results which are valid and reliable. The methods of assessment used must be appropriate to the learning outcomes, in line with current and best practice and be routinely monitored, quality assured and developed.

Requirement 17: Assessment must utilise feedback collected from a variety of sources, which should include other members of the dental team, peers, patients and/or customers.

Requirement 18: The provider must support students to improve their performance by providing regular feedback and by encouraging students to reflect on their practice.

Requirement 19: Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, including appropriate general or specialist registration with a UK regulatory body. Examiners/ assessors should have received training in equality and diversity relevant for their role. *(Requirement Partly Met)*

The panel learnt that all staff undertaking clinical assessments for the Division are GDC-registered. Staff undertaking non-clinical assessments of undergraduate students are experienced members of the research and teaching team.

The Division explained some of the processes in place for calibration of assessments.

We noted that the Division has already made some progress in the production of online calibration training videos. The panel recommend that they develop this further by considering in-person calibration of both examiners and actors used in OSCEs.

This Requirement is considered to be Partly Met.

Requirement 20: Providers must ask external examiners to report on the extent to which assessment processes are rigorous, set at the correct standard, ensure equity of treatment for students and have been fairly conducted. The responsibilities of the external examiners must be clearly documented. (*Requirement Partly Met).*

The Division explained that the University's Taught Programme Enhancement team in the central Teaching and Learning Delivery office (TLD) oversees the processes for nominating, appointing, and circulating EE reports. The programme team considers and acts on any EE comments and formally responds to them.

The panel had sight of a good range of EE reports. The reports were generally positive, and we saw evidence of improvements as a result of these in the assessment systems and professional services team.

We consider that the EEs should have full access to the papers prior to the exam and that an EE should be present at sign-up and sign-off meetings. At the April sign-up meeting we observed the EE was unable to attend and a recording of the meeting was being sent to them to review. This was not referred to during the subsequent sign-off meetings.

The panel were not able to see evidence of EEs having oversight for the final sign-off meeting. We were concerned that the absence of an EE was not addressed during the meeting and that there was no formal mechanism in place to capture feedback. While the EEs role was

evidenced throughout the programme, it was not utilised at a key progression point which lessened the panel’s confidence that EEs are used effectively.

This Requirement is therefore considered to be Partly Met.

Requirement 21: Assessment must be fair and undertaken against clear criteria. The standard expected of students in each area to be assessed must be clear and students and staff involved in assessment must be aware of this standard. An appropriate standard setting process must be employed for summative assessments.

Summary of Action

Requirement number	Action	Observations & response from Provider	Due date
4	1. The Division must continue to work on the development and implementation of the new staff to student supervision policy, covering all areas of clinical work and the various outreach centres.		End of Quarter 4 of 2024
5	2. The Division must consider a system to monitor mandatory staff training, including EDI and GDC registration.		End of Quarter 4 of 2024
9	3. The Division must provide an update to the ongoing curriculum mapping work to the GDC learning outcomes and preparation to move to the new Safe Practitioner Framework.		10 May 2024
10	4. The Division must continue the development of a more comprehensive risk register. 5.The Division must forward the service evaluation report when available. 6. The Division must ensure that a Student Experience Action Plan is actioned for the Dentistry Division. 7. The Division must continue to work on staff recruitment, development and succession planning.		End of Quarter 4 of 2024 End of Quarter 4 of 2024 End of Quarter 4 of 2024 End of Quarter 4 of 2024

11	8. The Division must ensure appropriate usage of the external examiner(s) at all decision points that determine whether a student will graduate the programme or not.		July 2025
12	9. The Division must provide completed audit forms from January 2024 and those from the expansion of placement provision. 10. The Division must consider expanding the employment basis of the new Lead for Outreach position. 11. The panel recommend that the Division consider the standardisation of induction and training for placement supervisors.		End of Quarter 4 of 2024 End of Quarter 4 of 2024 End of Quarter 4 of 2024
13	12. The Division must implement more explicit presentation of clinical data and give consideration to capturing the complexity of clinical experience. 13. The Division must address the apparent lack of differentiation in the threshold levels between basic and complex procedures.		End of Quarter 4 of 2024 End of Quarter 4 of 2024
14	14. The Division must continue to work on student monitoring systems which are in development.		End of Quarter 4 of 2024
15	15. The Division must ensure that student clinical data is captured with enough detail as to the complexity of the procedure so as to inform robust sign-up and sign-off decisions.		July 2025

19	16. The panel recommend that the Division continue to embed the standardisation and calibration of examiners by considering in-person calibration of both examiners and actors used in OSCEs.		End of Quarter 4 of 2024

Observations from the provider on content of report

Recommendations to the GDC

Education associates' recommendation	The BSc Oral Health Sciences continues to be approved for the current graduating cohort to apply for registration as a dental hygienist and a dental therapist with the General Dental Council. A reinspection of the programme is required in 2024/25 including attendance at all sign-off meetings.
Date of next regular monitoring exercise	Progress Monitoring: due dates as indicated against the Actions above.

Annex 1

Inspection purpose and process

1. As part of its duty to protect patients and promote high standards within the professions it regulates, the General Dental Council (GDC) quality assures the education and training of student dentists and dental care professionals (DCPs) at institutions whose qualifications enable the holder to apply for registration with the GDC. It also quality assures new qualifications where it is intended that the qualification will lead to registration. The aim of this quality assurance activity is to ensure that institutions produce a new registrant who has demonstrated, on graduation, that they have met the learning outcomes required for registration with the GDC. This ensures that students who obtain a qualification leading to registration are fit to practise at the level of a safe beginner.

2. Inspections are a key element of the GDC's quality assurance activity. They enable a recommendation to be made to the Council of the GDC regarding the 'sufficiency' of the programme for registration as a dentist and 'approval' of the programme for registration as a dental care professional. The GDC's powers are derived under Part II, Section 9 of the Dentists Act 1984 (as amended).

3. The GDC document 'Standards for Education' 2nd edition1 is the framework used to evaluate qualifications. There are 21 Requirements in three distinct Standards, against which each qualification is assessed.

4. The education provider is requested to undertake a self-evaluation of the programme against the individual Requirements under the Standards for Education. This involves stating whether each Requirement is 'met', 'partly met' or 'not met' and to provide evidence in support of their evaluation. The inspection panel examines this evidence, may request further documentary evidence and gathers further evidence from discussions with staff and students. The panel will reach a decision on each Requirement, using the following descriptors:

A Requirement is met if:

"There is sufficient appropriate evidence derived from the inspection process. This evidence provides the education associates with broad confidence that the provider demonstrates the Requirement. Information gathered through meetings with staff and students is supportive of documentary evidence and the evidence is robust, consistent and not contradictory. There may be minor deficiencies in the evidence supplied but these are likely to be inconsequential."

A Requirement is partly met if:

"Evidence derived from the inspection process is either incomplete or lacks detail and, as such, fails to convince the inspection panel that the provider fully demonstrates the Requirement. Information gathered through meetings with staff and students may not fully support the evidence submitted or there may be contradictory information in the evidence provided. There is, however, some evidence of compliance and it is likely that either (a) the appropriate evidence can be supplied in a short time frame, or, (b) any deficiencies identified can be addressed and evidenced in the annual monitoring process."

A Requirement is not met if:

"The provider cannot provide evidence to demonstrate a Requirement or the evidence provided is not convincing. The information gathered at the inspection through meetings with staff and students does not support the evidence provided or the evidence is inconsistent and/or incompatible with other findings. The deficiencies identified are such as to give rise to serious concern and will require an immediate action plan from the provider. The consequences of not meeting a Requirement in terms of the overall sufficiency of a programme will depend upon the compliance of the provider across the range of Requirements and the possible implications for public protection"

5. Inspection reports highlight areas of strength and draw attention to areas requiring improvement and development, including actions that are required to be undertaken by the provider. Where an action is needed for a Requirement to be met, the term 'must' is used to describe the obligation on the provider to undertake this action. For these actions the education associates must stipulate a specific timescale by which the action must be completed or when an update on progress must be provided. In their observations on the content of the report, the provider should confirm the anticipated date by which these actions will be completed. Where an action would improve how a Requirement is met, the term 'should' is used and for these actions there will be no due date stipulated. Providers will be asked to report on the progress in addressing the required actions through the monitoring process. Serious concerns about a lack of progress may result in further inspections or other quality assurance activity.

6. The Education Quality Assurance team aims to send an initial draft of the inspection report to the provider within two months of the conclusion of the inspection. The provider of the qualification has the opportunity to provide factual corrections on the draft report. Following the production of the final report the provider is asked to submit observations on, or objections to, the report and the actions listed. Where the inspection panel have recommended that the programme is sufficient for registration, the Council of the GDC have delegated responsibility to the GDC Registrar to consider the recommendations of the panel. Should an inspection panel not be able to recommend 'sufficiency' or 'approval', the report and observations would be presented to the Council of the GDC for consideration.

7. The final version of the report and the provider’s observations are published on the GDC website.